



Pharmacy



Prior Authorization Criteria for: Zelboraf (vermurafenib)

Background

Vermurafenib (Zelboraf) is an oral kinase inhibitor indicated for the treatment of patients with unresectable or metastatic melanoma with BRAFv600E mutation. Zelboraf is not recommended for use in wild-type BRAF melanoma. The FDA also approved a new molecular diagnostic test (Cobas 4800) designed to detect the BRAFv600E mutation and identify patients likely to respond to Zelboraf therapy.

The following criteria apply to prescriptions for vermurafenib obtained through the TRICARE Mail Order or retail network pharmacies as part of the TRICARE Program (TPHARM). The prior authorization form for vermurafenib is available on the TRICARE Pharmacy Prior Authorization page.

Effective Date – 6 June 2012

Prior Authorization Criteria for Zelboraf (vermurafenib)

- Coverage will be approved for the treatment of patients with documented diagnosis of unresectable or metastatic melanoma with BRAFv600E mutation, detected by a FDA-approved test such as Cobas 4800.
- Coverage will not be approved for patients with wild-type BRAF melanoma.

www.tricare.mil is the official Web site of the
TRICARE Management Activity,
a component of the [Military Health System](#)
Skyline 5, Suite 810, 5111 Leesburg Pike,
Falls Church, VA 22041-3206



Prior Authorization Request Form for Zelboraf (vemurafenib)



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To be completed and signed by the prescriber. To be used only for prescriptions which are to be filled through the Department of Defense (DoD) TRICARE pharmacy program (TPHARM). Express Scripts is the TPHARM contractor for DoD.

MAIL ORDER and RETAIL	<ul style="list-style-type: none">The provider may call: 1-866-684-4488 or the completed form may be faxed to: 1-866-684-4477The patient may attach the completed form to the prescription and mail it to: Express Scripts, P.O. Box 52150, Phoenix, AZ 85072-9954 or email the form only to: TPHarmPA@express-scripts.com
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Prior authorization criteria and a copy of this form are available at: http://pec.ha.osd.mil/forms_criteria.php. This prior authorization has no expiration date.

Step 1 Please complete patient and physician information (please print):

1	Patient Name: _____	Physician Name: _____
	Address: _____	Address: _____
	Sponsor ID #: _____	Phone #: _____
	Date of Birth: _____	Secure Fax #: _____

Step 2 Please complete the clinical assessment:

2	1. Does the patient have a documented diagnosis of unresectable or metastatic melanoma with BRAF ^{V600E} mutation that has been detected by an FDA-approved test such as Cobas 4800?	<input type="checkbox"/> Yes Proceed to Question 2	<input type="checkbox"/> No STOP Coverage not approved
	2. Does the patient have a wild-type BRAF melanoma?	<input type="checkbox"/> Yes STOP Coverage not approved	<input type="checkbox"/> No Sign and date below

Step 3 I certify the above is true to the best of my knowledge.

3	Please sign and date:
_____	_____
Prescriber Signature	Date

[6 June 2012]